CLAIM FOR REIMBURSEMENT FOR EXPENDITURES ON OFFICIAL BUSINESS

1. DEPARTMENT OR ESTABLISHMENT, BUREAU, DIVISION OR OFFICE

2. VOUCHER NUMBER

3. SCHEDULE NUMBER

Read the Privacy Act Statement on the back of this form.

5. PAID BY

4. CLAIMANT

a. NAME (*Last, first, middle initial*)

b. SOCIAL SECURITY NO.

c. MAILING ADDRESS (*Include ZIP Code*)

d. OFFICE TELEPHONE NUMBER

6. EXPENDITURES (*If fare claimed in col. (g) exceeds charge for one person, show in col. (h) the number of additional persons which accompanied the claimant.*)

DATE 19__ (a)	CODE (b)	Show appropriate code in col. (b): A—Local travel; B—Telephone or telegraph, or C—Other Expenses (*itemized*). (*Explain expenditures in specific detail.*) (c) FROM	(d) TO	MILEAGE RATE ¢ NO. OF MILES (e)	AMOUNT CLAIMED MILEAGE (f)	FARE OR TOLL (g)	ADD PER SONS (h)	TIPS AND MISCEL-LANEOUS (i)
If additional space is required continue on the back.			SUBTOTALS CARRIED FORWARD FROM THE BACK					
			TOTALS					

7. AMOUNT CLAIMED (*Total of cols. (f), (g) and (i).*) $

8. This claim is approved. Long distance telephone calls, if shown, are certified as necessary in the interest of the Government. (*Note: If long distance calls are included, the approving official must have been authorized, in writing, by the head of the department or agency to so certify (31 U.S.C. 680a).*)

Sign Original Only

APPROVING OFFICIAL SIGN HERE DATE

9. This claim is certified correct and proper for payment.

Sign Original Only

AUTHORIZED CERTIFYING OFFICER SIGN HERE DATE

10. I certify that this claim is true and correct to the best of my knowledge and belief and that payment or credit has not been received by me.

Sign Original Only

CLAIMANT SIGN HERE DATE

11. CASH PAYMENT RECEIPT

a. PAYEE (*Signature*)

b. DATE RECEIVED

c. AMOUNT $

12. PAYMENT MADE BY CHECK NO.

ACCOUNTING CLASSIFICATION (REVISED 7-65)

APPROPRIATION SYMBOL AND SUBHEAD	OBJECT CLASS	BUREAU CONT. AND SUBALLOT. NO.	AUTH. ACCTG. ACTIVITY	TYPE	PROPERTY ACCTG. ACTIVITY	COST CODE	AMOUNT

6. EXPENDITURES—*Continued*

DATE 19__ (a)	CODE (b)	*Show appropriate code in col. (b):* **A**—Local travel **B**—Telephone or telegraph, or **C**—Other Expenses *(itemized)* *(Explain expenditures in specific detail.)* (c) FROM	(d) TO	MILEAGE RATE ¢ NO. OF MILES (e)	AMOUNT CLAIMED MILEAGE (f)	FARE OR TOLL (g)	ADD. PERSONS (h)	TIPS AND MISCELLANEOUS (i)
				Total each column and enter on the front, subtotal line ▶				

In compliance with the Privacy Act of 1974, the following information is provided: Solicitation of the information on this form is authorized by 5 U.S.C. Chapter 57 as implemented by the Federal Travel Regulations (FPMR 101-7), E.O. 11609 of July 22, 1971, E.O. 11012 of March 27, 1962, E.O. 9397 of November 22, 1943, and 26 U.S.C. 6011(b) and 6109. The primary purpose of the requested information is to determine payment or reimbursement to eligible individuals for allowable travel and/or other expenses incurred under appropriate administrative authorization and to record and maintain costs of such reimbursements to the Government. The information will be used by Federal agency officers and employees who have a need for the information in the performance of their official duties. The information may be disclosed to appropriate Federal, State, local, or foreign agencies, when relevant to civil, criminal, or regulatory investigations or prosecutions, or when pursuant to a requirement by this agency in connection with the hiring or firing of an employee, the issuance of a security clearance, or investigations of the performance of official duty while in Government service. Your Social Security Account Number (SSN) is solicited under the authority of the Internal Revenue Code (26 U.S.C. 6011(b) and 6109) and E.O. 9397, November 22, 1943, for use as a taxpayer and/or employee identification number; disclosure is MANDATORY on vouchers claiming payment or reimbursement which is, or may be, taxable income. Disclosure of your SSN and other requested information is voluntary in all other instances; however, failure to provide the information (other than SSN) required to support the claim may result in delay or loss of reimbursement.

CLAIM FOR REIMBURSEMENT FOR EXPENDITURES ON OFFICIAL BUSINESS

1. DEPARTMENT OR ESTABLISHMENT, BUREAU, DIVISION OR OFFICE

2. VOUCHER NUMBER

3. SCHEDULE NUMBER

Read the Privacy Act Statement on the back of this form.

5. PAID BY

4. CLAIMANT

a. NAME (*Last, first, middle initial*)

b. SOCIAL SECURITY NO.

c. MAILING ADDRESS (*Include ZIP Code*)

d. OFFICE TELEPHONE NUMBER

6. EXPENDITURES (*If fare claimed in col. (g) exceeds charge for one person, show in col. (h) the number of additional persons which accompanied the claimant.*)

DATE 19__ (a)	CODE (b)	(c) FROM	(d) TO	MILEAGE RATE ¢ NO. OF MILES (e)	AMOUNT CLAIMED MILEAGE (f)	FARE OR TOLL (g)	ADD PER SONS (h)	TIPS AND MISCEL-LANEOUS (i)

Show appropriate code in col. (b): **A**—Local travel; **B**—Telephone or telegraph, or **C**—Other Expenses (*itemized*)

(*Explain expenditures in specific detail.*)

If additional space is required continue on the back.

SUBTOTALS CARRIED FORWARD FROM THE BACK

TOTALS

7. AMOUNT CLAIMED (*Total of cols. (f), (g) and (i).*) $

8. This claim is approved. Long distance telephone calls, if shown, are certified as necessary in the interest of the Government. (*Note: If long distance calls are included, the approving official must have been authorized, in writing, by the head of the department or agency to so certify (31 U.S.C. 680a).*)

Sign Original Only

APPROVING OFFICIAL SIGN HERE DATE

9. This claim is certified correct and proper for payment.

Sign Original Only

AUTHORIZED CERTIFYING OFFICER SIGN HERE DATE

10. I certify that this claim is true and correct to the best of my knowledge and belief and that payment or credit has not been received by me.

Sign Original Only

CLAIMANT SIGN HERE DATE

11. CASH PAYMENT RECEIPT

a. PAYEE (*Signature*)

b. DATE RECEIVED

c. AMOUNT $

12. PAYMENT MADE BY CHECK NO.

ACCOUNTING CLASSIFICATION (REVISED 7-65)

APPROPRIATION SYMBOL AND SUBHEAD	OBJECT CLASS	BUREAU CONT. AND SUBALLOT. NO.	AUTH. ACCTG. ACTIVITY	TYPE	PROPERTY ACCTG. ACTIVITY	COST CODE	AMOUNT

6. EXPENDITURES—*Continued*

Show appropriate code in col. (b):
A—Local travel
B—Telephone or telegraph, or
C—Other Expenses *(itemized)*

(Explain expenditures in specific detail.)

DATE 19__ (a)	CODE (b)	(c) FROM	(d) TO	MILEAGE RATE ¢ / NO. OF MILES (e)	AMOUNT CLAIMED: MILEAGE (f)	FARE OR TOLL (g)	ADD. PER-SONS (h)	TIPS AND MISCEL-LANEOUS (i)
			Total each column and enter on the front, subtotal line ▶					

In compliance with the Privacy Act of 1974, the following information is provided: Solicitation of the information on this form is authorized by 5 U.S.C. Chapter 57 as implemented by the Federal Travel Regulations (FPMR 101-7), E.O. 11609 of July 22, 1971, E.O. 11012 of March 27, 1962, E.O. 9397 of November 22, 1943, and 26 U.S.C. 6011(b) and 6109. The primary purpose of the requested information is to determine payment or reimbursement to eligible individuals for allowable travel and/or other expenses incurred under appropriate administrative authorization and to record and maintain costs of such reimbursements to the Government. The information will be used by Federal agency officers and employees who have a need for the information in the performance of their official duties. The information may be disclosed to appropriate Federal, State, local, or foreign agencies, when relevant to civil, criminal, or regulatory investigations or prosecutions, or when pursuant to a requirement by this agency in connection with the hiring or firing of an employee, the issuance of a security clearance, or investigations of the performance of official duty while in Government service. Your Social Security Account Number (SSN) is solicited under the authority of the Internal Revenue Code (26 U.S.C. 6011(b) and 6109) and E.O. 9397, November 22, 1943, for use as a taxpayer and/or employee identification number; disclosure is MANDATORY on vouchers claiming payment or reimbursement which is, or may be, taxable income. Disclosure of your SSN and other requested information is voluntary in all other instances; however, failure to provide the information (other than SSN) required to support the claim may result in delay or loss of reimbursement.

ANNUAL CERTIFICATE OF PHYSICAL CONDITION

Date: _____

Instructions:

This certificate is to be completed annually by members of the naval service (including Reserves) as required by the Manual of the Medical Department and other directives, as appropriate. **The intentional failure to disclose an illness or disease could be construed as an intent to defraud the Government and could result in the member's loss of disability benefits or be the basis for criminal prosecution or other administrative action under the Uniform Code of Military Justice.**

Type or clearly print member's name (last, first, middle initial); social security number; and unit to which assigned.

The member shall complete the appropriate responses, sign in ink, and date.

1. Last Name, First Name, Middle Init.			2. SSN	3. Rate/Rank
4. Designator/MOS/NEC	5. Sex	6. Age	7. Date of Birth	
8. Known Allergies			9. Unit or School and UIC	
10. Home Address	Street		City	
11. State	Zip + 4 Code		Home Phone Number	Work Phone Number
12. Location of Health Record			13. Location of Dental Record	
14. Date of last Complete Physical Examination			15. Purpose of Examination	
16. Date of last Dental Exam	17. Type of Examination		18. Class	19. Date of last PAP and results / 20. Date of last Mammogram and results
21. Date of last HIV Blood Test	22. Blood Pressure *Reserves Only*		23. Body Fat %	24. Height / 25. Weight

(Continued on Reverse)

ANNUAL CERTIFICATE OF PHYSICAL CONDITION

1. Have you had any injury, illness or disease within the past 12 months which required hospitalization or caused you to be absent from school, duty or civilian occupation for more than 3 consecutive days?
   ( ) NO ( ) YES **If yes, explain:** _____

2. Are you now, or have you been under a physician's care during the past 12 months?
   ( ) NO ( ) YES **If yes, explain:** _____

3. Have you taken prescription medications in the past 12 months?
   ( ) NO ( ) YES **If yes, what are they?** _____

4. Do you have any physical defect(s), family or mental problems which might restrict your performance on active duty or prevent your mobilization?
   ( ) NO ( ) YES **If yes, explain:** _____

5. Additional comments: _____

Upon completion of indicated action, file completed certificate in member's Health Record and a copy in member's Dental Record.

I certify that the information contained in this form is true and complete to the best of my knowledge and belief.

MEMBER'S SIGNATURE: _____

MEDICAL DEPT. REP. SIGNATURE: _____

REVIEWING OFFICER'S SIGNATURE: _____

REVIEWING OFFICER'S COMMENTS: _____